Wisconsin Department of Health and Family Services
Division of Public Health
DPH 4725 (Rev. 10/01)

P.O. Box 6645
Madison, WI 53716-6645
(608) 221-3846

PROVIDER PARTICIPATION AGREEMENT

The following program and administrative specifications are required as a condition of this Agreement. The full complement of screening program services includes program-approved Wisconsin Well Woman Program (WWWP) screening, re-screening, and diagnostic procedures, individual case management and follow-up services.

By signing this agreement, the Provider, whether an individual, agency or other entity, agrees to meet and abide by the terms and conditions of the WWWP manual and this Agreement.

General Requirements

1. This agreement shall be effective upon approval by the WWWP and shall continue in effect until September 29, 2004 or such time as either party terminates the agreement in accordance with the process described in paragraphs 2 and 3 of this agreement.

2. Except as provided in paragraph 3, either party may terminate this agreement with or without cause. Thirty (30) day written notice from WWWP to provider or vice versa will terminate this agreement. WWWP will notify the fiscal agent of the termination date.

3. If the provider is in violation of this agreement or any other federal or state law, the Wisconsin Department of Health and Family Services (DHFS), Division of Public Health (DPH), WWWP may immediately terminate this Agreement. In the event of termination, DHFS shall reimburse the provider for services provided prior to the termination date.

4. The provider will comply with applicable Federal and State laws prohibiting discrimination in the delivery of service on the basis of race, color, disability, creed, national origin, ancestry, sexual orientation, arrest or conviction record, marital status, religion, or payment source and to make available a Client Complaint procedure in the event of such discrimination.

5. Maintain client confidentiality.

6. Designate one person, at each provider site, as the contact person and specify the name of this person on the Agreement application.
   a. Any change in the contact person must be reported to the WWWP within 30 days. This person will be responsible for providing and disseminating WWWP information.

7. Comply with all WWWP data collection requirements.

8. Send completed WWWP reporting forms to the fiscal agent: screening and diagnostic test results; final diagnosis; if invasive cancer diagnosed, note stage and tumor size; and the date that treatment is initiated, when needed.

9. Use only laboratories that comply with the standards and regulations promulgated by the HCFA implementing the Clinical Laboratory Improvement Act (CLIA) of 1988.

10. Participate in public and professional education activities conducted or sponsored by the WWWP.

11. Retain WWWP client records for a minimum of five (5) years and **make them available upon request by an authorized representative of the WWWP**. Failure to retain adequate documentation for any service billed may result in recovery of payments for services not adequately documented.

12. Obligations under the Agreement shall be suspended at such time as funds are not available to cover payment for services provided to eligible clients. However, suspension shall not eliminate coverage under this Agreement for services which had been approved by the WWWP and which had already been furnished prior to the date of suspension.

Service Provisions

13. Provide services on behalf of the Wisconsin DHFS, DPH, WWWP, as needed, to eligible, enrolled clients.

14. Track all women screened through the WWWP following guidelines set forth in Chapter 5 of the WWWP Manual.

15. Ensure that documentation of the results of all WWWP approved services performed on an eligible woman are placed in the individual's permanent medical records.

16. Contact the local coordinator within 10 working days after the notification of abnormal screening results with recommended client follow-up appointments and/or referrals.

17. Ensure that any WWWP client who requires diagnostic testing and/or treatment will receive such testing and treatment within 60 days of the abnormal result.

18. Participate with the WWWP local coordinating agency in recruiting and retaining WWWP clients through inreach and outreach activities.

Reimbursement Related Requirements

19. WWWP is the payer of last resort.

20. Payments to providers for services shall be in compliance with the WWWP reimbursable services and rates at the time of service delivery.

21. WWWP shall reimburse providers based on the allowable Medicare reimbursement rates.

22. Determine if women, eligible under the WWWP, have third party reimbursement that covers screening for any WWWP approved services and bill such parties before billing WWWP.

23. Services authorized and the resulting charges are subject to review and approval by the WWWP's fiscal agent.

24. **Not to require or request payment for authorized services from clients covered by this Agreement**. Authorized services are listed in Chapter 4 of the WWWP Manual.

25. The provider **must** notify WWWP clients of services not covered by the WWWP, **prior to performing them** The Provider may bill clients for services not covered under this Agreement.

26. Submit completed WWWP reporting forms with the HCFA billing forms to the fiscal agent.

In Addition to the Above, Providers of Breast and Cervical Cancer Screening Services Agree:

27. Adhere to the federal Centers for Disease Control and Prevention (CDC) required program guidelines for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) contained in the WWWP Manual. The WWWP will provide a copy of the guidelines to each Provider.

28. Follow the NBCCEDP breast and cervical cancer screening guidelines through increased public and professional education, outreach, screening and follow-up of women at high risk for breast and cervical cancer.

29. Establish and maintain a system for the appropriate follow-up and referral of women with abnormal or suspicious screening tests.

30. Provide assurances that women with abnormal findings on examinations have access to accepted and appropriate follow-up care and treatment, when indicated.

31. Not to use WWWP funds for treatment services.

32. Utilize mammography units certified by the Food and Drug Administration (FDA) and maintain evidence of this certification on file.

33. Use the American College of Radiology (ACR), Breast Imaging Reporting and Data System (BIRADS) for reporting the interpretation of mammography examinations and the "Bethesda" Reporting System for reporting Pap smear results.

34. Maintain adequate and complete fiscal and medical records to fully document services provided to clients under terms of this Agreement.

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PROVIDER PARTICIPATION AGREEMENT

Service Provider Name (Name to appear on Provider Listing) If multiple Providers, complete back of this agreement.	Payment Mailing Address (Street, City, State, Zip, County)
Name of Authorized Representative (Please Print)	Service Provider Address (Street, City, State, Zip, County) If multiple addresses, complete back of this agreement.
Signature of Authorized Representative	Contact Person: (If multiple sites, provide name of contact at each site on the back of this agreement)
Date	Telephone Number ( ) _____ _____

Please Check One and Enter Number:

- ❑ Social Security Number: _____
- ❑ Federal Tax ID Number: _____
- ❑ CLIA certification Expiration date:_____
- ❑ MQSA certification Expiration date: _____

If you are referring clients/tests to satellite facilities, please list them on the back of this agreement.

Type of WWWP Screening Services to be provided (Check all that apply)

Office or Outpatient Visits:

Breast: CBE_____ Diagnostic consultation____
Surgical ____ Anesthesia____

Cervical: Pelvic_____ Pap_____ Colposcopy_____

Cardiovascular: Blood pressure_____ Risk assessment____

Diabetes: Risk assessment_____

Osteoporosis: Risk assessment_____

Domestic Abuse: Risk assessment_____

Mental Health: Depression screen_____

Radiology:

Breast: TC _____ 26 _____

Laboratory

Cervical: Pap
Cardiovascular: Diabetes_____ Lipids_____

Pathology Services:

Breast: TC_____ 26_____
Cervical: TC _____ 26 _____

PROVIDER ENROLLMENT APPROVED

Agreement Number _____

Wisconsin Division of Public Health Authorizing Signature Date

_____

PROVIDER PARTICIPATION AGREEMENT
(Continued)

Site/Contact Persons

Site name (Name to appear on service provider listing)____
Address (Street, City, State, Zip, County) ____
____
Contact person__________________________________ Telephone number_________________________
Email Address___________________________________

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Site name (Name to appear on service provider listing)____
Address (Street, City, State, Zip, County) ____
____
Contact person__________________________________ Telephone number_________________________
Email Address___________________________________

~~~~~

Site name (Name to appear on service provider listing)____
Address (Street, City, State, Zip, County) ____
____
Contact person__________________________________ Telephone number_________________________
Email Address___________________________________

~~~~~

Site name (Name to appear on service provider listing)____
Address (Street, City, State, Zip, County) ____
____
Contact person__________________________________ Telephone number_________________________
Email Address___________________________________

~~~~~

Site name (Name to appear on service provider listing)____
Address (Street, City, State, Zip, County) ____
____
Contact person__________________________________ Telephone number_________________________
Email Address___________________________________

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Referral sites

Cervical: Laboratory
Site name____________________________________
❏ CLIA certification Expiration date:_______

Cervical: Laboratory
Site name ____________________________________
❏ CLIA certification Expiration date:________

Cervical: Pathology
Site name ____________________________________
❏ CLIA certification Expiration date:________

Cervical: Pathology
Site name ____________________________________
❏ CLIA certification Expiration date:________

Breast: Radiology
Site name ____________________________________
❏ MQSA certification Expiration date: _______

Breast: Radiology
Site name ____________________________________
❏ MQSA certification Expiration date: _______

Breast: Pathology
Site name____________________________________
❏ MQSA certification Expiration date: _______

Breast: Pathology
Site name ____________________________________
❏ MQSA certification Expiration date:________

Expanded: Laboratory
Site name____________________________________
❏ CLIA certification Expiration date:________

Expanded: Laboratory
Site name ____________________________________
❏ CLIA certification Expiration date:________
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PROVIDER DATA SHEET FOR THE WISCONSIN WELL WOMAN PROGRAM

ADD_____ UPDATE_____

SECTION I

PROVIDER MEDICAID NUMBER_____

SECTION II

Name and **physical or work** address of individual, agency or other entity requesting certification.

NAME _____

ADDRESS _____

_____

CITY _____ STATE_____ ZIP_____

COUNTY _____ EMAIL ADDRESS_____

SECTION III

1. **Payee name** and **address** (where checks are mailed) if different from above.

   NAME _____

   ADDRESS _____

   _____

   CITY _____ STATE_____ ZIP_____

2. Contact _____ Telephone ( )_____

3. Payee's Federal ID/IRS# _____ OR

   Social Security #_____

4. Email Address_____

_____ _____

Date Authorized Representative of Provider

Send Completed Forms to:

WWWP
P.O. Box 6645
Madison, WI 53716-0645

ADDITIONAL NAME/MEDICAL ASSISTANCE NUMBERS FOR THE WISCONSIN WELL WOMAN PROGRAM

Submit only with Provider Data Sheet

ADD_____ UPDATE_____

Individual Medicaid Number	**Name associated with Individual MA Number**	**Provider's Medicaid Number (from Section 1)**